INITIAL INTAKE FORM

Patient Information

Patient Name	
Date of Birth	Age:
Grade	
Address	
Phone Number	Home: Cell:
Email Address	

Referring Physician's Name	
Physician's Phone Number	

Parent/Guardian Information

Parent/Guardian Name	Best Contact Number	Relationship

Emergency Contacts (Not Parents/Guardian Listed Above)

Emergency Contact Name	Best Contact Number	Relationship

Authorized Person(s) That May Pick Up the Child (Not Listed Above)

Contact Name	Best Contact Number	Relationship

Preferred method of communication:

____Phone call ____Text ____Email ____Phone App ____Other (Explain Below)

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Bright Speech Therapy requests this information for the purpose of completing a thorough evaluation of the patient. Depending on the patient's abilities, some questions may not be applicable.

Case History

- FAMILY HISTORY -

Total number of family members residing in the home (include patient): __________

Is there any known history of the following in the immediate or extended family?

- ☐ Autism/PPD
- ☐ ADHD
- ☐ Learning Disabilities
- ☐ Hearing Loss
- ☐ Stuttering
- ☐ Speech/Language Delays

Please describe the family member's difficulties and relationship to the patient.

- CONCERNS -

When did you first have concerns about your child?

What made you concerned?

What strategies/techniques have you been trying thus far?

What is your primary concern today?

What would you like your child to achieve in therapy?

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- PATIENT HISTORY -

Medical History

Was the patient ever evaluated by the following?

____Psychiatrist

____Psychologist

____Physical Therapist

____Occupational Therapist

____Otolaryngologist (Ear, nose, throat)

____Orthodontist

____Neurologist

If yes, please indicate the name, date, and reason.

List any medications (antibiotics, etc) the patient is currently taking:

Medication	Dose	Reason

List any food or environmental allergies the patient has:

Allergies	Severity Level	What happens?

List any procedures the patient has undergone:

Surgery	Surgery Date	The doctor who performed the surgery.

Has your child experienced any of the following? (please check all that apply)

☐ Chicken Pox
☐ Cleft Palate/Lip
☐ Vision Problems
☐ Seizures
☐ Feeding Tube
☐ Gastroesophageal Reflux
☐ Frequent ear infections or fluid in the ear.
☐ PE Tubes (If so, when?) ________________

When was the last time your child's hearing was evaluated? ______________________________

By who? Results? ____

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Does the patient have any other diagnoses not related to speech, language, hearing? Yes | No
If yes, please list:

Developmental History

Describe the mother's health during pregnancy. Please include illnesses and the month(s), length of delivery, instruments used, induced labor, complications during delivery, complications post-delivery, etc.

Did the patient have difficulty with feeding/latching during the postnatal period? If so, please explain.

Pregnancy: (Circle)

Full-Term | Pre-Term (before 37 weeks) | Post-Term (after 42 weeks)

Please check all that apply and fill in necessary information:

____Breastfed (Age Range ____________________ months)

____Bottle-Fed (Age Range ____________________ months)

____Pacifier Used (Age Range ____________________ months)

____Sucking Thumb (Age Range ____________________ months)

____Feeding Difficulties (Please explain: ____________________

____Sleeping Difficulties

____Hearing Problems (e.g. failed infant hearing tests, not attending to sound, etc.)

Fill in the ages the following were accomplished.

Holding head up: ____________________ Cooing: ____________________

Sitting unassisted: ____________________ Babbling: ____________________

Crawling: ____________________ First word: ____________________

Walking: ____________________ 2-words together: ____________________

Bowel/bladder trained: ____________________ Full sentences: ____________________

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- CURRENT SKILLS -

Speech, Language, Hearing

Has the patient previously received speech therapy? Yes / No

If yes, please describe the diagnosis, attendance period, where services were received, sample goals targeted, etc. (or attach copies of such documentation/reports).

What is the patient's primary mode of communication? (Circle all that apply) - gestures / signing / single words / short phrases / sentences / augmentative devices / picture exchange / other

How many words does the patient say (expressive)? ______________________

How many words does the patient understand (receptive)? ______________________

How much of your child's speech do you understand?

☐ 10% or less ☐ 11-24% ☐ 25-50% ☐ 51-74% ☐ 75-100%

How much of your child's speech do others understand?

☐ 10% or less ☐ 11-24% ☐ 25-50% ☐ 51-74% ☐ 75-100%

Does your child demonstrate frustration when he/she is not understood? Yes / No (If so, please explain.)

Play & Social Skills

Does your child engage in eye contact during communication? Yes / No / Sometimes

When given a choice, does your child prefer to play alone or with others? Alone / Other

How does your child interact with others (shy, aggressive, cooperative)?

Does your child:

Answer questions logically?	Yes / No / Sometimes
Greet people arriving or leaving?	Yes / No / Sometimes
Engage in turn taking?	Yes / No / Sometimes
Initiate conversation?	Yes / No / Sometimes
Maintain a topic?	Yes / No / Sometimes
Recall and tell about everyday events?	Yes / No / Sometimes
Follow 1-step directions?	Yes / No / Sometimes

What are some of your child's favorite toys/interests?

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- EDUCATION -

Does your child attend school? If so, where and how often.

Please indicate services your child receives at school. (Circle all that apply) - speech therapy | occupational therapy | physical therapy | tutoring | Other ___________________________________

May we communicate with the school therapists to collaborate services? Yes | No
If yes, please complete the "Release of Information" form and provide a copy of your child's most current IEP.

Does your child experience any challenges at school? Yes | No
If yes, please explain.

- OTHER -

Is there any other information that you would like us to know regarding your child?